DERMATOLOGY CLINIC OF IDAHO

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Advance Beneficiary Notice (ABN)

Date: ____ /____ /____

Patient Name: _____ Date of Birth: ____ /____ / ____

Procedure: _____

Your signature on the bottom of this form signifies that you understand that the service identified above is not a covered benefit under your insurance plan. Your decision to have this service rendered and your signature indicates an understanding that the procedure is performed strictly for cosmetic purpose, is not medically necessary, and therefore, should not and will not be submitted to your managed care plan for payment.

You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and will not be reimbursed by your health care plan.

Treatment: _____

Charge: _____ Payment Method: _____

_____ ____ / ____ / ____
Patient Signature Date

_____ ____ / ____ /____
Witness Date